MDR Tracking Number: M5-04-3985-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 07-21-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, neuromuscular stimulation, unlisted therapeutic procedure, paraffin bath, hot/cold pack therapy, chiropractic manipulative treatment, vasopneumatic device, electrical stimulation and ultrasound were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 08-13-03 through 12-17-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 23rd day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

September 13, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-3985-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, nerve conduction study and radiology reports.
Information provided by Respondent: correspondence and designated doctor exam.

Clinical History:
This is a 30-year-old right-handed female who stated she injured her left wrist and elbow on ___ when she was reaching across the countertop for a boat anchor. She experienced sudden pain in her left wrist and left elbow and then presented for treatment.

Disputed Services:
Office visits, neuromuscular stimulation, unlisted therapeutic procedure, paraffin bath, hot/cold pack therapy, chiropractic manipulative treatment, vasopneumatic device, electrical stimulation, and ultrasound during the period of 08/13/03 through 12/17/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
The objective tests, the NCV and MRI, showed no physical damage to the left elbow and left wrist. There is no documentation of any continuing improvement in any objective measure for range of motion, strength, or function that justifies the therapy. As therapy progresses, there should be a decrease in the frequency and intensity of the therapy with a gradual transition to a home program. Physical therapy can be a reasonable part

of a rehabilitation program following injury or procedure, but there must be some demonstrative benefit from the therapy in order to establish medical necessity. According to the Mercy Guidelines, after about 4 weeks of manual procedures without significant documented improvement in the treatment, the continuing treatment may not be appropriate and alternative care should be considered in the absence of the documented pathology or objective benefit. The medical necessity of reviewed services is not established in the medical notes.

The patient does not appear to be responding to the care as would be expected based on the prolonged period of care and the treatment that is being reported during this stage of treatment. The provider offered no rationale as to the need for such a long treatment. Other than the daily notes, there is no subjective visible analog scale used to show improvement per the Official Disability Guidelines, 8th Edition. The records do not contain any medical objective evidence or documentation such as aggravation and/or exacerbation that would warrant or explain the need for any ongoing treatment at that time. Furthermore, continuing to render such treatment as to a claimant 3½ months post injury and 45 or more similar treatments have already been given to the claimant for this injury is considered somewhat excessive and not in keeping with the disability guidelines.

Sincerely,